Investigation into the circumstances surrounding the death of a man at outside hospital in July 2011 whilst in the custody of HMP Wandsworth

Report by the Prisons and Probation Ombudsman for England and Wales

March 2012

This is the report of an investigation into the death of a man, a prisoner at HMP Wandsworth. He died at outside hospital in July 2011, having been taken ill in his cell six days earlier. He was 66 years old. The preliminary cause of death was found to be severe ischaemic heart disease. I offer my sincere sympathy and condolences to the man's family, and to all who have been affected by his loss.

The investigation was carried out by one of my investigators. I am grateful for the cooperation of the Governor and his staff at HMP Wandsworth. A review of the man's clinical care in custody was carried out by a clinical reviewer on behalf of Wandsworth Primary Care Trust.

Although he was taking medication for high blood pressure and high cholesterol, the man died unexpectedly. My investigation finds that staff responded appropriately when he was taken ill on the night of 22 July, although I believe that an ambulance should have been called more quickly and make a recommendation in the light of this finding. I make two further recommendations which relate to the monitoring of ongoing medical conditions at Wandsworth. A further recommendation relates to breaking the news of the man's death to his cell mate.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2012**

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SUMMARY

1. The man was arrested in the United States of America in April 2007, and later sentenced to 13 years and four months imprisonment. He applied for a transfer to the United Kingdom and subsequently arrived at Wandsworth on 2 December 2009. Before his arrest, he had been diagnosed with an enlarged prostate gland (the main function of the prostate is to produce fluid to protect and enrich sperm) as well as high blood pressure and high cholesterol. The clinical reviewer finds that these conditions were not appropriately monitored during the man's time at Wandsworth, although she adds that this is unlikely to have contributed to his death. Nevertheless, the clinical reviewer and Ombudsman make two recommendations with regard to the monitoring of such conditions.

2. During his time at Wandsworth, the man worked in the prison's media centre. He was liked by those prisoners who knew him and described by staff as someone who worked extremely well. Those who saw him at work on the day he was taken ill said that he appeared to be his normal self.

3. On the night of 22 July, the man told his cell mate he had a severe headache and he went to bed earlier than usual. At around 11.30pm, the man made a choking noise and his cell mate pressed the emergency call bell to summon assistance. The night patrol, an operational support grade (OSG), responded promptly and made an appropriate radio call for assistance. By this time the man was not breathing and staff opened the cell and began cardio-pulmonary resuscitation (CPR). However, an ambulance was not called until healthcare staff arrived, some five minutes after the cell bell was pressed. A nurse took over CPR until the paramedics arrived and the man was taken to hospital shortly afterwards. He spent five days on a life support machine before the decision was made to switch this off. The man died shortly afterwards.

4. We find that the response on 22 July was, on the whole, timely and appropriate. Nonetheless, we believe that an ambulance might have been called when staff were first alerted to the man's illness and make a recommendation regarding the importance of requesting an ambulance at the earliest opportunity in potentially life threatening situations. However, we are unable to say that this would have made a difference to the final outcome for this man.

THE INVESTIGATION PROCESS

5. The investigation was opened on 1 August 2011 when the investigator issued notices announcing the investigation to staff and prisoners. These notices included an invitation to those who wished to submit information relating to the man's death to make themselves known. One prisoner wrote to the investigator as a result.

6. The investigator visited Wandsworth on 2 August. During the visit he saw the cell in which the man had lived, and the media centre where he worked. The investigator spoke to staff and prisoners who knew the man both from his unit and place of work. The investigator also met the prison's family liaison officer and was provided with copies of the man's prison records.

7. The investigator visited HMP Belmarsh on 8 August, where he interviewed the man's former cell mate. He returned to Wandsworth on 15 September and 4 October, and interviewed four members of staff.

8. A clinical review of the man's clinical care in custody was undertaken by a clinical reviewer on behalf of Wandsworth Primary Care Trust.

9. One of the Ombudsman's family liaison officers contacted the man's niece on 30 August 2011. Along with her mother, the man's niece acted as his nominated next of kin. The family liaison officer explained the purpose of the investigation and provided the opportunity for the man's family to raise any concerns about his care at Wandsworth. The man's niece subsequently received a copy of the draft report as part of the consultation process. We are grateful for the time she has taken to consider the report and for the feedback provided, which is included on page 13. We hope this report clarifies any issues that might remain unclear for the man's family and provides an understanding of what happened in the time leading to his death.

HMP WANDSWORTH

10. Wandsworth is the largest prison in England and Wales, holding up to 1,665 convicted and unconvicted adult men. Its catchment area includes courts in central and south west London and neighbouring Home Counties. Wandsworth is a category B local prison. (Category B prisoners are those who do not require maximum security, but for whom escape needs to be made very difficult.) Some prisoners will serve the whole of their sentence at Wandsworth, while others will be moved to other prisons, including lower category ones, as appropriate.

11. The man lived on the Onslow unit throughout his time at Wandsworth. This is a large residential unit consisting of three wings (G, H and K) and is for vulnerable prisoners (those who need to be, or request to be, separated from other prisoners for their own safety). The cells on the Onslow unit are doubles, mostly with bunk beds although some have separate single beds.

12. HM Chief Inspector of Prisons last inspected Wandsworth in March 2011. The Chief Inspector concluded that the treatment of many prisoners at Wandsworth "fell below what could be classed as decent". Whilst he highlighted forums that were held on the Onslow unit to establish the needs of older prisoners, he reported that there were delays implementing improvements recommended. Relationships between staff and prisoners were reported to be much better on the Onslow unit than in other areas of the prison. The Chief Inspector also recommended that prisoners with life long health conditions have access to the appropriate clinics.

13. The Independent Monitoring Board (IMB, a body of unpaid local people who independently monitor and report on the prison) annual report for 2009-10 reported that relationships between staff and prisoners had deteriorated because of an area-wide shortage of staff. They also reported that nursing staff responded promptly and appropriately to emergencies and serious incidents.

14. This is the 14th death that the Ombudsman has investigated at Wandsworth since January 2010. Five of the previous deaths were due to apparent natural causes, as was the one subsequent death at the prison. The investigation into one of the recent deaths reported that discipline staff did not start cardio-pulmonary resuscitation (CPR) when they found a prisoner unresponsive, as they were not trained and preferred to wait for trained healthcare staff to arrive. The report suggested that the Governor consider providing the Emergency First Aid at Work course to a spread of staff.

KEY EVENTS

15. Following a biopsy undertaken when he lived in Brazil in 2006, the man was diagnosed with an enlarged prostate gland. (The main function of the prostate is to produce fluid to protect and enrich sperm. Many older men develop an enlarged prostate, which can lead to problems involving the frequency or flow of urination.) He was later arrested and imprisoned in the United States of America, before transferring the United Kingdom in December 2009. On his arrival at Wandsworth, on 2 December 2009, the man explained his medical history to a nurse at a first reception health screen (a routine health screen for all new arrivals into prison). He told the nurse that he had regular blood tests on account of his enlarged prostate. (These blood tests check the prostate specific antigen (PSA) which is a protein produced by cells of the prostate gland. An elevated PSA level in the blood could indicate prostate cancer or various urinary conditions.) He also explained that he had high blood pressure and high cholesterol. His medication was listed as amlodipine and lisinopril (both used to treat high blood pressure), bendroflumethiazide (to treat fluid retention and help the body pass water more quickly) and aspirin (used to prevent blood clots).

16. Over the following days, the man completed the induction process and was allocated a cell on the Onslow unit. A risk assessment was completed, following which he was able to keep his medication 'in-possession' (meaning that a week or several weeks' medication is supplied to the prisoner, to keep in a lockable cabinet in their cell and take as prescribed).

17. The man saw a prison doctor on 21 December, following a referral that was made by the reception nurse. After the man had explained his medical history, the doctor asked that a blood test be taken to check his PSA. This was taken the following day, with the results showing that his PSA was five times the normal maximum. There is no indication that the results were discussed with him, or that any action was taken.

18. Other than collecting his medication, the man had little contact with the healthcare team over the following nine months. His compliance with his medication was reviewed in March 2010, as part of a standard assessment for prisoners aged over 60. It was recorded that he was fully compliant and had no issues with side effects.

19. In October, the man had a routine abdominal aortic aneurysm screening. (An abdominal aortic aneurysm is the widening of the artery in the abdomen, usually on account of high blood pressure. This can balloon and rupture, which can be fatal.) The results of the screening were normal and no follow up was required.

20. A blood sample was taken in December following a request by a second prison doctor. The results were normal and no further action was recommended. It does not appear as though the man's PSA was tested as part of this process. The doctor also asked that the man's blood pressure be checked but there is no indication that it was taken or of what the results might have been.

21. The last recorded interaction between the man and healthcare staff (other than collecting his medication on a monthly basis) took place on 4 March 2011. This was a follow up appointment, as he had recently complained of a fungal infection on his fingernails. He was given a cream to apply and no significant concerns were recorded.

22. Staff and prisoners who knew him said there was no change in the man in the days before he was taken ill. A prisoner who worked with him in the media centre said that he seemed fine on the afternoon of 22 July and recalled that he was "chatting, walking around and having a laugh". A prisoner who lived in the cell next door to the man recalled seeing him in the dinner queue later that afternoon. He also remembered that he seemed to be his usual self.

23. The man's cell mate told the investigator that the man did not follow his usual pattern of behaviour after lock up on the night of 22 July. He explained that the man usually went to bed at around 12.30am and would spend the time beforehand writing. On the night of 22 July, however, he said he was tired and he did not therefore write. At around 10.30pm to 10.45pm, he said he had a severe headache. His cell mate gave him two ibuprofen tablets that he had spare. The man went to bed at around 11.30pm, and told his cell mate that he was retiring earlier than usual on account of his headache.

24. Shortly after he went to bed, the man made a noise that his cell mate described as "like choking or a deep snore". He shouted his name, but the man did not respond. The cell mate got out of bed to check on him, and found him blue in the face. He pressed the emergency call bell to request assistance. The call bell log records that the bell was pressed at 11.32pm.

25. During the night three operational support grade (OSG) staff work on the Onslow unit, each having responsibility for one of the wings. They each carry a radio and a sealed pouch containing a cell key, which they can break and use to open a cell only in an emergency. A female OSG was responsible for H wing on the night of 22 July. (The man lived in cell H2-02, a ground floor cell.) She went to the cell and reset the call bell 24 seconds after it had been pressed. (The call bell must be reset at the cell to allow it to be used again. This also allows the time that staff respond to be recorded.) The man's cell mate told the investigator that he checked his cell mate's pulse in this time and found that it was faint. He recalled that his cell mate was not able to communicate and "it appeared as though he was not breathing".

26. The man's cell mate told the OSG on her arrival that he thought the man had stopped breathing. She therefore made a 'code one' call on her radio for emergency assistance. (A code one call indicates that urgent medical assistance is required.) The control room log records that this call was made at 11.33pm. The OSG also shouted for her two colleagues (fellow OSGs) on the unit to come to the cell. They were both in the staff office, which is a matter of metres from the cell, and therefore arrived quickly. The OSG explained that she was about to break her sealed pouch to obtain a cell key when the night orderly officer (the person in charge of the prison on site overnight), and her colleague arrived in response to the radio call for assistance. The night orderly officer

explained that she and her colleague were very close to H wing when the call was made and they therefore arrived at the man's cell quickly.

27. The man's cell mate told the investigator that there was a delay of around 25 to 30 seconds before the door was opened following the night orderly officer's arrival. He said this was because the staff wanted him to lift the sheet that was covering the man so they could see what was wrong. The night orderly officer, on the other hand, said that she unlocked the cell as soon as she arrived. The OSG could not recall the conversation to which the cell mate referred.

28. The night orderly officer told the investigator that when she went into the cell the man was "making a gurgling noise" and was blue in colour. She did not think that he was breathing, and she and her colleague therefore began cardiopulmonary resuscitation (CPR). The night orderly officer recalled that they used a ratio of 15 compressions to one breath and that he was lying on his bunk at the time.

29. Around a minute later, a nurse arrived at the cell. She applied an oxygen mask, asked the staff present to move the man onto the floor, and took over CPR with her colleague. The night orderly officer then made a radio call to request that an emergency ambulance be called. This call was recorded as being made at 11.37pm.

30. The ambulance crew arrived at Wandsworth at 11.49pm and were taken to the man's cell. At 11.59pm, it was recorded that he had no pulse and was not breathing. At 12.13am a pulse was identified. He was taken to the ambulance and left the prison at 12.30am. The night orderly officer authorised that restraints did not need to be used, as the man was so unwell.

31. The duty governor was contacted and told that the man had been taken to hospital in an emergency. He came into the prison and spoke to all of the staff involved to offer support and ensure that they were well. Those staff to whom the investigator spoke were appreciative of the duty governor's input. The duty governor told the investigator that he chose not to contact the man's next of kin immediately because it was late at night and he did not have full information about his condition.

32. The following morning, the duty governor spoke to staff at the hospital and passed on the contact details of the man's nominated next of kin, his brother. Hospital staff subsequently made contact. The man's niece visited him in hospital that morning and her mother (the man's sister) visited later in the day. They took over responsibility as the next of kin. He remained in hospital on life support for nearly a week. On an afternoon in late July, the life support machine was switched off in the presence of the man's niece and cousin. He died later that afternoon.

33. The man's funeral was arranged for 9 August and was led by the prison chaplain at a local crematorium. The prison contributed towards the funeral expenses.

ISSUES

PSA Monitoring

34. As noted, the man was diagnosed with an enlarged prostate gland following a biopsy undertaken in Brazil in 2006. He told staff following his arrival at Wandsworth that he had regular blood tests to monitor his PSA. A blood test was taken following a review by a prison doctor on 21 December 2009. The results showed that his PSA was very high (22.6 micrograms per litre (ug/L) compared to the stated normal range of 0.0 – 4.0 ug/L). There is no indication that these results were reviewed, discussed with him, or that any follow up action was taken. The man's PSA was not tested again during his time at Wandsworth.

35. The clinical reviewer comments that the lack of review of the man's PSA result is unlikely to have contributed to his death. However she considers that it should have been reviewed and makes the following recommendation:

    The head of healthcare should ensure that a robust system is in place so that all medical tests ordered by clinical staff are seen by a prison doctor – preferably the prison doctor that ordered them – and that a note is made in the clinical records to include any further action.

Blood pressure monitoring

36. At his reception health screen, the man said that he had high blood pressure. It does not appear that his blood pressure was checked on arrival or at any stage during his time at Wandsworth, even though he continued to take medication for this condition (known as anti-hypertensives). In December 2010, a prison doctor asked that the man's blood pressure be checked and his blood tested. The blood test took place, but there is no note of his blood pressure being taken.

37. The clinical reviewer notes the National Institute for Health and Clinical Excellence (NICE) guidelines, which suggest that patients with high blood pressure should be reviewed yearly. She goes on to comment that the man's review with the prison doctor meets this target. However, the review was not sufficient as the man's blood pressure was not taken or recorded.

    The head of healthcare should ensure that prisoners who are prescribed anti-hypertensive medication have their blood pressure monitored as instructed by NICE guidelines.

Events of 22 July 2011

38. The initial staff response to the emergency call bell on the night of 22 July was appropriate. The OSG arrived at the cell quickly and made the appropriate radio call for assistance on being told that the man had stopped breathing. There are conflicting views regarding the speed with which staff subsequently opened the cell. The man's cell mate told the investigator that it was around 25 to 30 seconds after the arrival of the night orderly officer that the cell was opened, as the staff wanted him to first lift the sheet that was covering the man so they could

see what was wrong. All of the staff recalled that the cell was opened as soon as the night orderly officer arrived and could not recall the conversation to which the cell mate referred. Without the assistance of closed circuit television, we are unable to say for certain which version of events is correct. However, it is reasonable that staff would wish to fully assess the situation before opening the cell.

39. After examining the man, the night orderly officer concluded that he was not breathing. With the assistance of her colleague, she began CPR. They used a ratio of 15 compressions to one breath and administered CPR whilst the man was lying on his bed. We understand that current Resuscitation Council (UK) guidelines advise a ratio of 30 compressions to two breaths is most appropriate. Best practice also recommends that it be administered with the patient placed on a hard surface, such as the floor.

40. The night orderly officer said that it is "many years" since she was trained in CPR and she has not been refreshed since. The OSG said that she was trained in April 2011 and her training was therefore up to date. Whilst it is commendable that the night orderly officer and her colleague took the initiative and administered CPR, in future circumstances it would be advisable that freshly trained staff take on this responsibility. However, we note that the night orderly officer and her colleague administered CPR for just a minute before the arrival of a nurse who took over and asked that the man be moved to the floor.

41. The OSG made a code one call for assistance on arrival at the man's cell when his cell mate told her he had "stopped breathing". As we have noted, the night orderly officer began CPR after going into the man's cell. Nevertheless, an ambulance was not requested until after the arrival of the nursing staff. The call to request an ambulance was made at 11.37pm. The OSG said that she did not think about calling an ambulance when she made the code one call. The night orderly officer said that her first priority on getting to the cell was to start CPR and she called the ambulance once the nurse was able to take over.

42. In February 2011 the Chief Executive Officer of the National Offender Management Service (NOMS, the organisation responsible for the Prison and Probation Services in England and Wales), wrote a letter to Governors. He said that:

> "It should not be a requirement in every case for a member of the prison healthcare team to attend the scene before emergency services are called … The most important aspect of emergency care is that an ambulance is called in all cases where there are grave concerns about the immediate health of a prisoner."

43. As staff were told that the man was not breathing, it is our view that it would have been appropriate to ask for an ambulance at the same time as the code one call for assistance was made. Failing that, a call could have been made when the man's cell was opened and CPR commenced. There were a number of staff present at the time, all of whom carried radios, and any one of them could have made this call.

The Governor should ensure that the local guidance on dealing with an emergency reflects the contents of the Chief Executive Officer of the National Offender Management Service's letter of February 2011, and that the guidance is re-issued to all staff.

Breaking the news of the man's death to his cell mate

44. Following a court appearance on 27 July, the man's cell mate moved to HMP Belmarsh. He did not receive an update on the man's condition following this move. Although he was aware that he was on life support and close to death, he was not formally told of his former cell mate's death until his interview with the investigator on 8 August.

The Governor should ensure that arrangements are in place to break the news of a death to any prisoner closely involved in the events who has subsequently transferred to another establishment.

FAMILY RESPONSE TO THE DRAFT REPORT

45. We received a number of comments from the man's niece on the draft report, which we discuss below.

Ongoing clinical care

46. The man's niece questioned why his blood pressure and PSA were not monitored at Wandsworth, despite his history of high blood pressure and enlarged prostate. As we have noted in paragraphs 34-37, the clinical reviewer considers that these measures ought to have been taken during the man's time in prison. We have recommended that the head of healthcare ensure that such tests take place and are reviewed appropriately for those prisoners for whom they are relevant (recommendations one and two). These recommendations were accepted by the prison and an action plan has been completed (see 'Recommendations' section for details).

47. The man's niece also asked whether it was safe for him to have been given an influenza vaccination, given his high blood pressure and heart condition. He had the vaccination on 31 October 2010. The NHS document 'Flu-jab: why it should be done' lists at risk groups who should have the vaccination and can therefore receive it for free. This list includes those with chronic heart disease. The document also sets out those who should not have the vaccination: none of the conditions with which the man had been diagnosed are included in the list.

Emergency response

48. We received a number of comments from the man's niece about the emergency response when he was taken ill on 22 July 2011, and the first aid and CPR training that staff receive. Firstly, she asked why an ambulance was not called immediately when staff went into her uncle's cell. As we have noted in paragraph 41, the OSG told the investigator that she did not think to call an ambulance whereas the night orderly officer said that her first priority was to call an ambulance. We conclude that it would have been appropriate for an ambulance to have been requested at the same time as the 'code one' call for assistance. Following our recommendation (recommendation three), Wandsworth have confirmed that staff will be reminded by the Governor of the importance of calling an ambulance in all cases where there are concerns about the immediate health of a prisoner (see 'Recommendations' section for details).

49. The man's niece asked why her uncle's cell mate was taken out of the cell and to a separate room before an ambulance was called, as she thought calling for assistance should have been given priority. It was important to remove the cell mate so that the cell was clear for CPR to take place, and also to offer him support. We think there were enough staff present for this to be feasible without a detrimental impact on the emergency response. However, we agree that an ambulance should have been called at an earlier stage and that this should have been a priority.

50. In addition, the man's niece asked why the night orderly officer carried out CPR when she has not had training for a number of years. She also asked whether staff working on the Onslow unit were sufficiently trained in first aid and CPR to deal with such emergencies. All OSGs who work nights at Wandsworth have up to date CPR training, including the three who worked on the Onslow unit on the night of 22 July. We consider this to be sufficient provision as it ensures that there are trained staff on each unit overnight. However, as noted in paragraph 39, we think, in any future emergency, it would be advisable for freshly trained staff to take on the responsibility of CPR. We note that the night orderly officer and her colleague administered CPR for just a minute before the nurse arrived and took over.

Events following the man's death

51. The man's niece said that the prison's family liaison officer was very helpful and supportive to the family throughout. However, she added that, when the family collected the man's belongings from the prison, they were given what appeared to be everything from his cell, including the bedding. The man's niece thought this was inappropriate and that some items should have been separated.

52. Prison service guidance on liaison with a bereaved family following a death in custody currently states that the prison's family liaison officer "should consult the family about how they would like to retrieve their belongings". From 1 April 2012 this instruction becomes mandatory and states that the prison family liaison officer "must" consult the family about how they would like to receive property.

53. It is unfortunate that the man's family received his property in a condition in which they were unhappy. We consider it important that property is returned to a bereaved family in a manner of their choosing, not least because it helps to convey they message that the death is of proper concern to the prison. In future circumstances, it would be advisable for the family liaison officer to clarify, during the mandatory consultation set out above, which items of property the family would like to receive.

54. The man's niece also said that she had to contact the prison the day after her uncle died, when the prison's family liaison officer was unavailable. She contacted another governor via email but, rather than receiving a direct reply, was copied into an email to other staff within the prison. (The specific email is from that governor to another governor, asking him to process the funeral expenses in the family liaison officer's absence. The man's niece was copied into the email, along with numerous other members of prison staff.) The man's niece found this insensitive and inappropriate, particularly as it happened so soon after her uncle had died. We are sorry to hear that the man's niece was upset by these events. They act as a reminder to prison staff that the bereaved family should usually be contacted separately and not involved in internal prison correspondence.

CONCLUSION

55. The man was an older prisoner with some long standing health problems. As we have noted, these should have been monitored more closely during his time at Wandsworth. Nevertheless, he did not raise any significant concerns about his health at the prison and appeared to be well in the days leading up to his apparent heart attack.

56. The response when the man was taken ill on the night of 22 July was, in general, prompt and appropriate. However we believe that an ambulance should have been called at an earlier stage. Whilst we cannot say that this would have made a difference to the final outcome, the Governor should remind staff of the importance of requesting an ambulance at the earliest opportunity.

RECOMMENDATIONS

1. The head of healthcare should ensure that a robust system is in place so that all medical tests ordered by clinical staff are seen by a prison doctor – preferably the prison doctor that ordered them – and that a note is made in the clinical records to include any further action.

   Accepted – This action has been forwarded to the GP team who will review and set an action plan on the process of how information received from laboratories about blood and other results is monitored for normal results and/or ongoing prisoner care. The GP team are in the process of formulating this, so this will be forwarded as soon as possible.

2. The head of healthcare should ensure that prisoners who are prescribed anti-hypertensive medication have their blood pressure monitored as instructed by NICE guidelines.

   Accepted - Introduction of second day reception screening process ensures BP is recorded at reception. Prisoners can be referred to wing nurse or B2 clinic for BP monitoring.

   Register of prisoners with hypertension to be created and system for maintaining up to date register developed. (Initially list of those on hypertension medications from pharmacy will be used to create this).

   System in place to ensure register is regularly monitored so that prisoners are called for annual BP review as appropriate.

   Weekend BP monitoring clinics to be established on B2/GHK with all clinicians/staff able to refer prisoners for monitoring.

   Local BP monitoring protocol for referral back to GP/ANP for review to be agreed.

   GPs/ANPs in the Heathfield Healthcare centre to review treatment for those referred to them.

   Prisoners with hypertension to be given appropriate written information in second day screening about the importance of ensuring they have their BP checked at least annually.

3. The Governor should ensure that the local guidance on dealing with an emergency reflects the contents of letter of February 2011, and that the guidance is re-issued to all staff.

   Accepted – A Governors Information Notice to staff will be published, outlining the local guidance on dealing with an emergency. This will reflect the contents of the Chief Executive Officer of the National Offender Management Service's letter of February 2011.

4. The Governor should ensure that arrangements are in place to break the news of a death to any prisoner closely involved in the events who has subsequently transferred to another establishment.

   Accepted – The local contingency plans for dealing with a death in custody will be amended to include an action for the establishment to break the news of a death to any prisoner closely involved in the events who has subsequently transferred to another establishment.